XXXXXXXXXXXXXXXX
DENTAC Patient Safety Officer

XXXXXX Dental Clinic

# *RISK MANAGEMENT PATIENT SAFETY*

***ONE CONCEPT OF PATIENT SAFETY:***

# *HOW DO THESE TWO THINGS RELATE?*

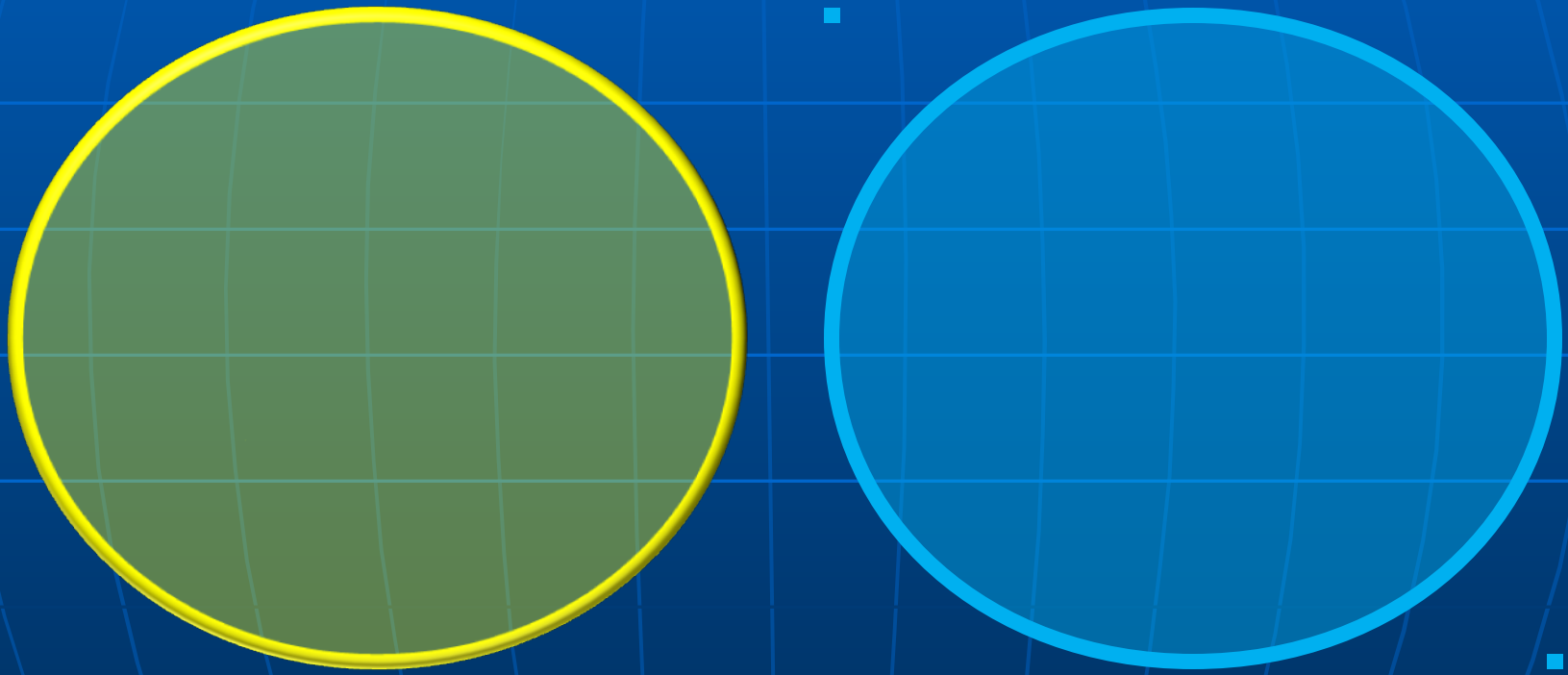
***RISK MANAGEMENT***

**+**

***QUALITY***

# *PATIENT SAFETY*

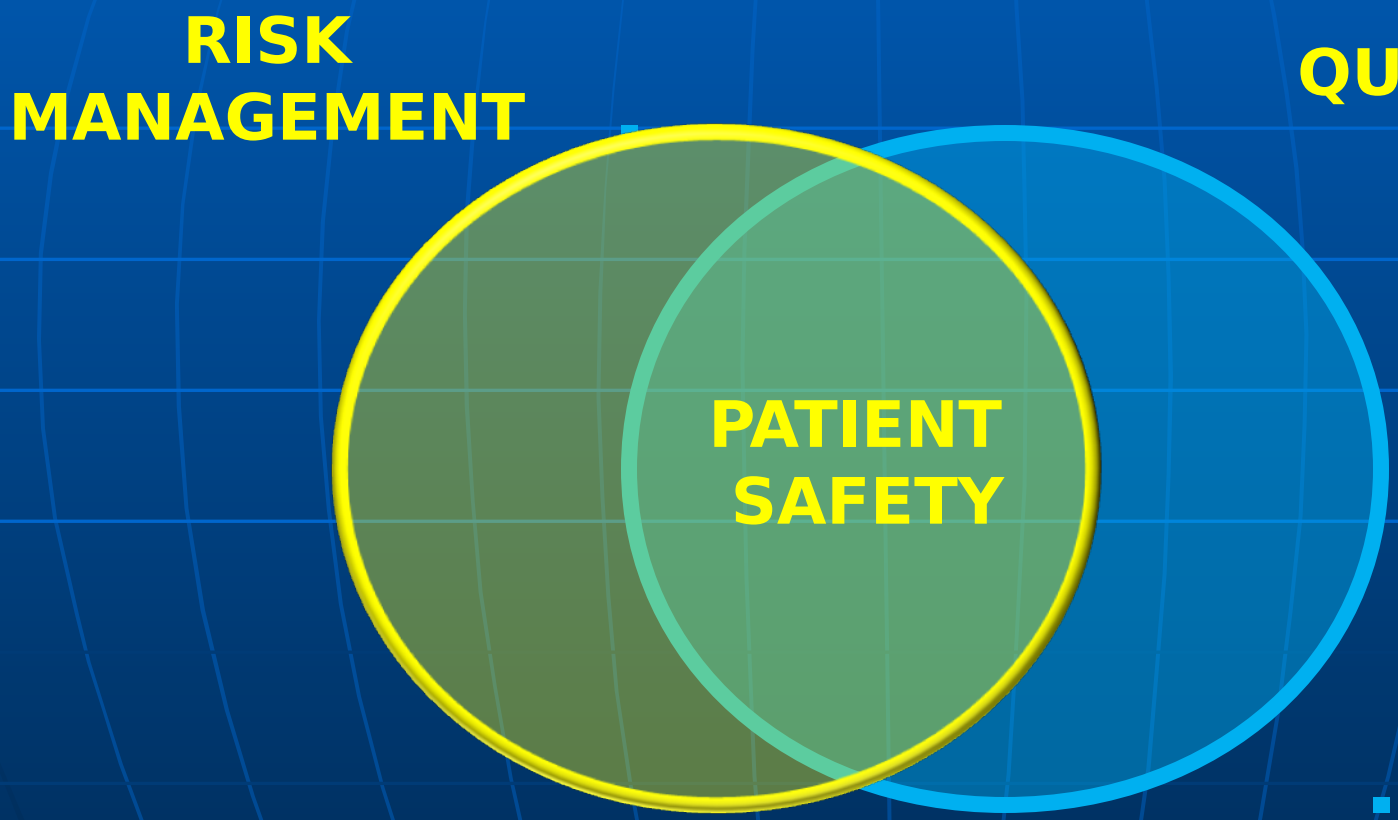
# *HOW DO THESE TWO THINGS RELATE?*



**RISK MANAGEMENT**

**QUALITY**

# *HOW DO THESE TWO THINGS RELATE?*



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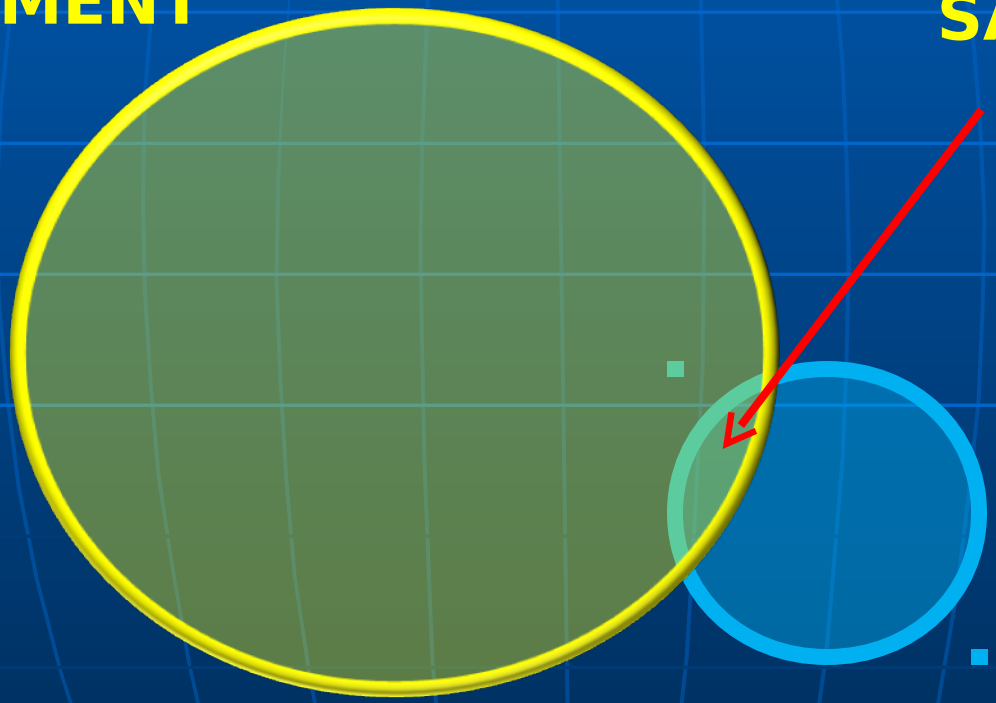
**RISK MANAGEMENT**

**PATIENT SAFETY**



**QUALITY**

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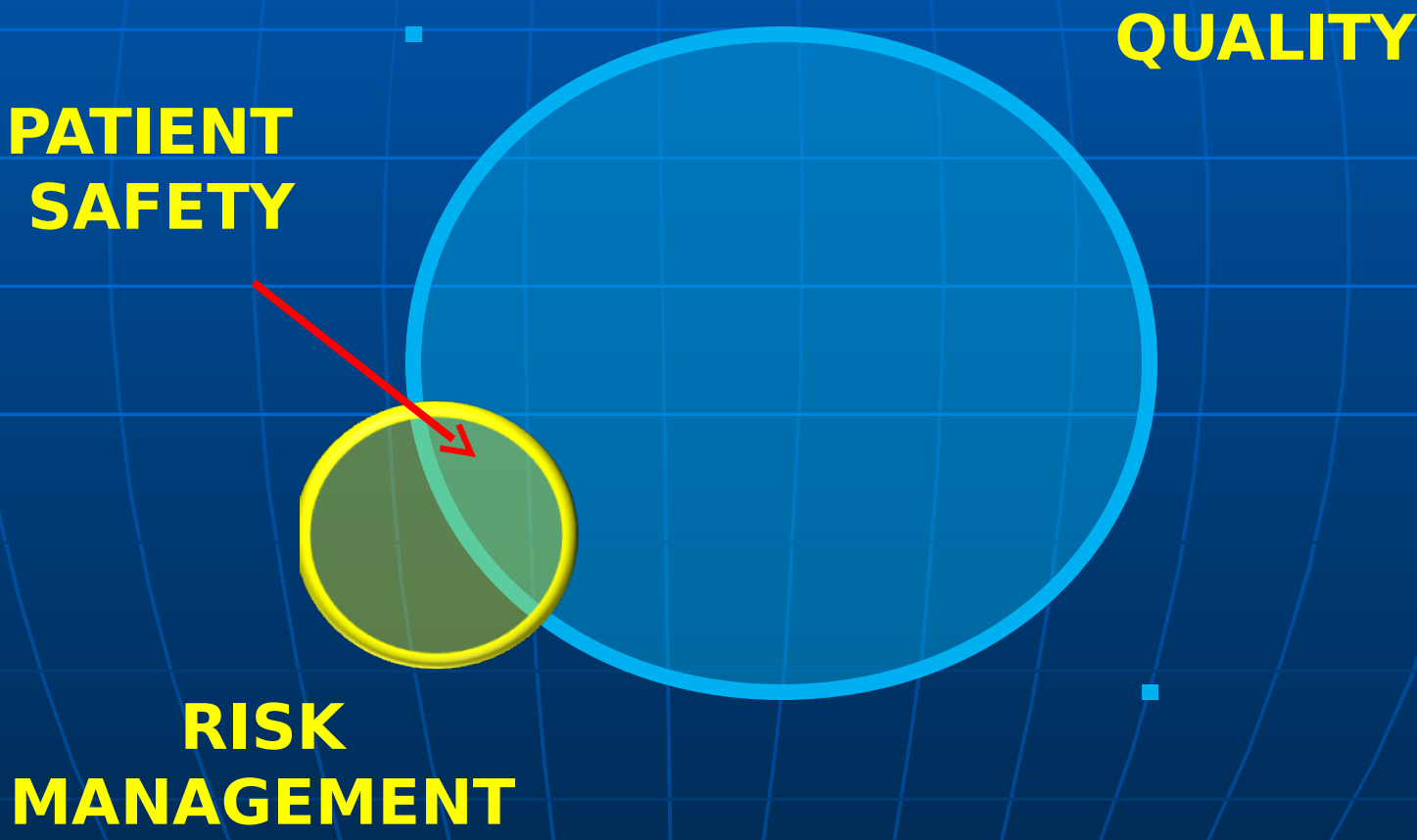
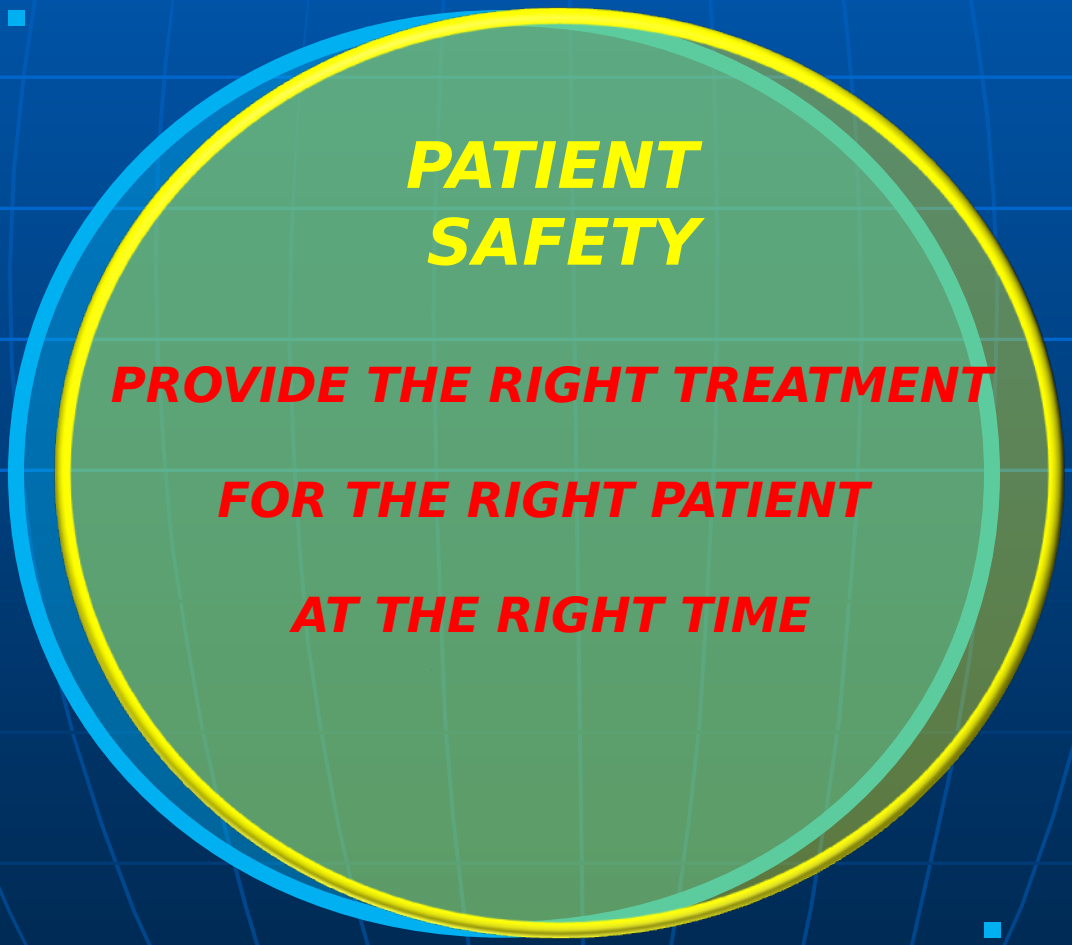


# *WHAT IS DENTAC'S PATIENT SAFETY GOAL?*

**RISK MANAGEMENT**

**QUALITY**

# WHAT IS OUR DENTAC'S PATIENT SAFETY GOAL?



# *Risk Management*
# What is it?

***Facilities***

***Employees***

***Patient***

"SAFETY" PERSPECTIVE

"PATIENT SAFETY" PERSPECTIVE

# *Risk Management*
# What Is It?

- *Risk = Chance of loss*
  - Monetary
  - Injury
  - Patient confidence/compliance
  - Employee confidence/compliance/loyalty
  - Intangible components

# *Risk Management*
# What Is It?

- *<u>Organizational</u>: **DENTAC decides** how to minimize or avoid loss **for you***

- *<u>Individual</u>: **You personally decide** how to minimize or avoid loss*

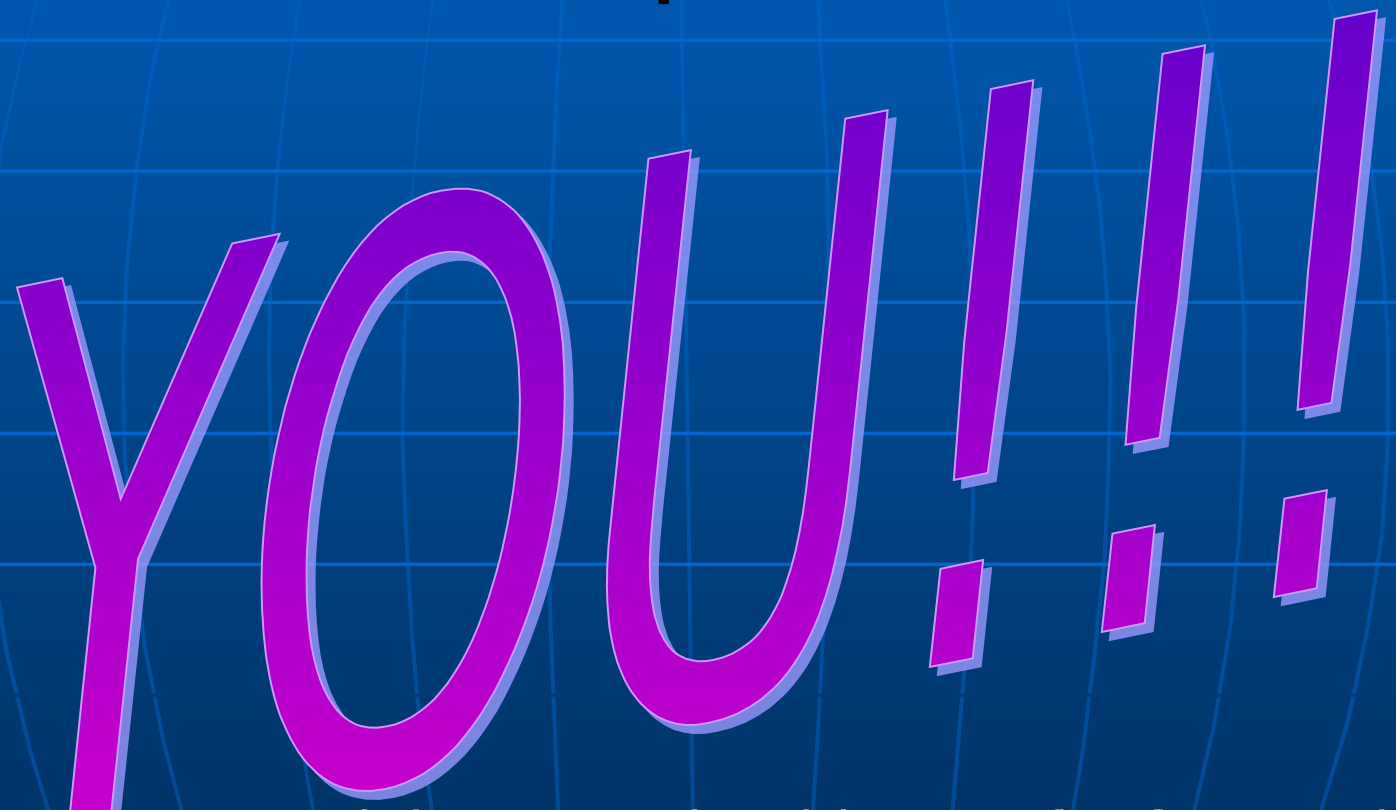
# *Risk Management*
# Who is responsible?

- *Commanders*
- *OICs*
- *NCOICs*
- *Providers*
- *Employees*
- *Maintenance staff*

EVERYONE

# *Risk Management*

## Who is responsible?




*What are YOU doing to make things safer for you (as an employee) and your patients?*

# *Risk Management*
# How do "I" find risky situations?

- *Be alert for situations or actions which can result in loss*
  - Unusual occurrences - Patients
    - Death
    - Patient returns for same problem same area
    - Wrong patient/wrong record
    - Wrong site treatment – *"Wrong Site Surgery"*
      - Fill/treat wrong tooth, wrong area
      - Extract wrong tooth
    - Unsafe practices
    - Adverse reaction to medication
    - Injury - Falls, cuts, bruises

# *Risk Management*
# How do "I" find risky situations?

- *Look for situations/actions which can result in loss for you or others*
  - Unusual occurrences – Self/Employees
    - Sharps injury
    - Blood-borne pathogen exposure
    - Needle-sticks
    - Occupational Illness/Injury
      - Falls, sprains, etc.

# *Risk Management*
# How else do "I" find risky situations?

- *Learn more*
  - Use training to really learn – Don't just *"show up"*
  - Learn and use what you learn from training *TeamSTEPPS,* OPD, NCOPD, CDR's Call
- *Look for ways to reduce risky situations*
- Near Misses
- Actual incidents
- Engage in peer review
- Review DoD/CQ logs
- Complete and learn from drug audits
- Learn from Safety and patient safety reports
- Perform standard of care reviews when possible

# *Risk Management*

## How else are risky situations identified?

- *Safety checks done often…*
  - People
    - Providers qualifications/skills evaluated continuously
      - Patient evaluations / customer service
      - Peer review/recommendations
      - Credentialing/Privileging
      - Drug audits
      - Random urinalysis
    - Staff
      - Performance evaluations
      - Re-certifications, i.e. CPR

# *Risk Management*

## How else are risky situations identified?

- *Safety checks done often… (Cont'd)*
  - Facilities
    - Equipment
      - Safety checks
      - Routine maintenance
    - Environment
      - Industrial hygiene inspections
- *When something serious does occur, DENTAC investigates to see what can be improved to reduce risky situations in the future*

# *ROOT CAUSE ANALYSIS REPORT TO THE COMMANDER*

*XXXXXXXXXXXXXXXXXX Incident*

*DENTAC Headquarters*

*XXJUNXX*

# *ROOT CAUSE ANALYSIS "RCA"*

*Formal investigation surrounding an adverse event involving a patient*

*Patient sustained temporary or permanent*

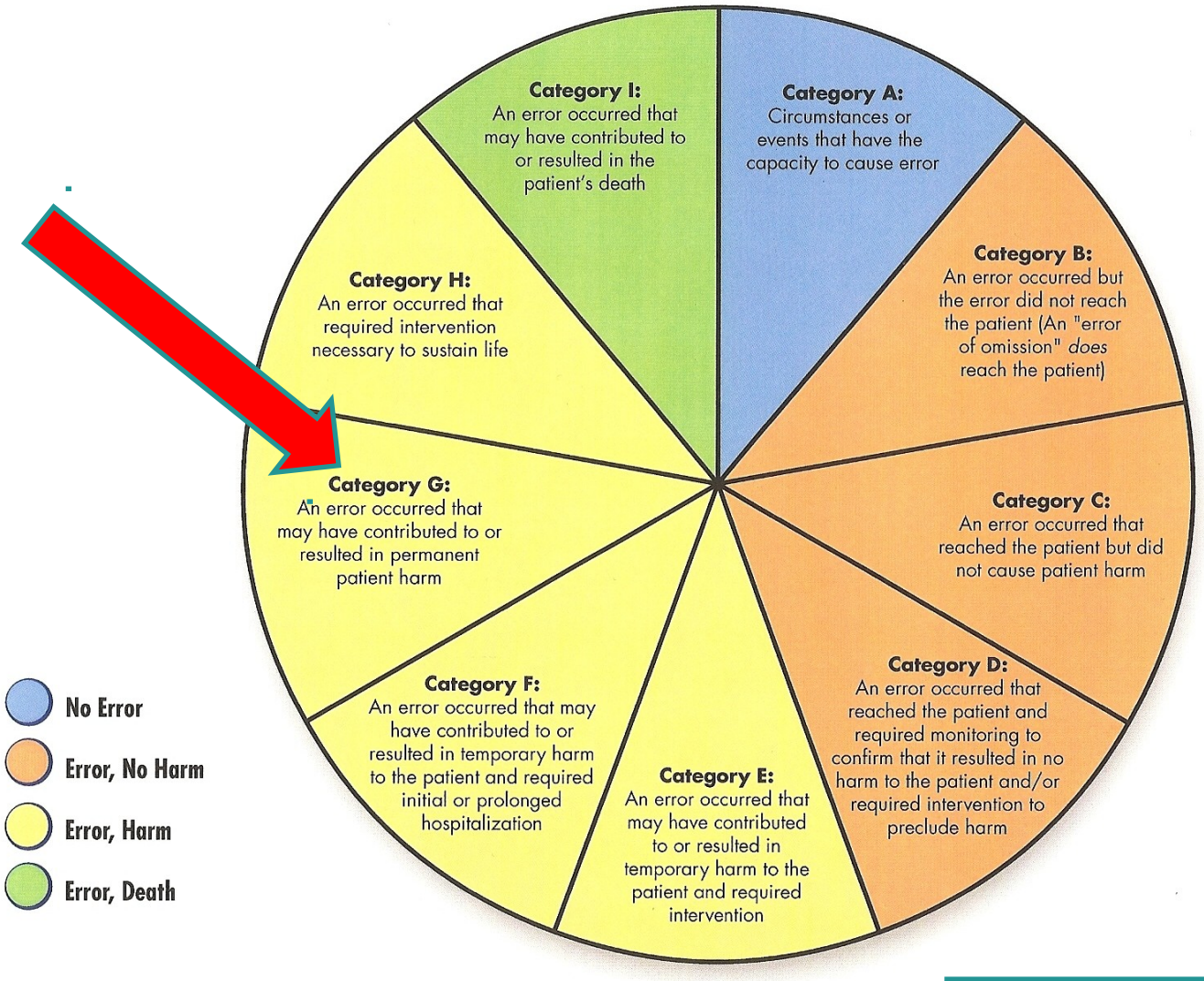
# DENTAC XXXXXXX Root Cause Analysis Timeline

- *Timeline*
  - 27JUNXX – Adverse event occurred @ X DC
  - 30JUNXX - DENTAC made aware of event
  - 04JULXX - Informal findings presented to QA Committee
  - 05JULXX - RCA Team Chartered
    - COL A (Leader)
    - COL B (Member)
    - CPT C (Member)
    - Mr. Smith (Advisor)
    - LTC Xcellent (Consultant)

# DENTAC XXXXXXXX Root Cause Analysis Timeline

- *Timeline (Continued)*
  - 09JULXX – RCA Team meeting
    - Received Just-in-time RCA training
    - Evaluated case documentation
    - Reviewed Correct Site Surgery Policy (40-46)
    - Deliberated
    - Created report and action plan
  - 12JULXX – RCA final report presented to DENTAC CDR
  - 15JULXX – RCA final report forwarded to Regional Commander then to MEDCOM Patient Safety Center

# NCC MERP Index for Categorizing Medication Errors




## Definitions

**Harm**
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

**Monitoring**
To observe or record relevant physiological or psychological signs.

**Intervention**
May include change in therapy or active medical/surgical treatment.

**Intervention Necessary to Sustain Life**
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.)



Incident rated Category F or higher:
RCA warranted

# *Root Cause Analysis Determination*

- *Root Cause Determination:*
  - Communication breakdown between staff members
  - Human performance error significantly contributed to this adverse (sentinel) event

- *Other potential causes were ruled out by the RCA process*

# *Root Cause Analysis Additional Findings*

- *Incomplete or erroneous documentation displayed in many dental record entries surrounding this incident include:*
  - No time out
  - No diagnosis or justification for extraction(s)
  - Procedural details minimal
  - No pre-operative or post-operative blood pressure readings
  - Incorrect tooth numbering
  - No time of appt
- *Existing documentation deficiency could significantly contribute to adverse events in the future*

# *Risk Management*
# How do "I" put this into action?

- *Communicate!*
  - If you see something risky, do something to interrupt it
    - If you can't do it, get someone who can (Supervisor / NCOIC/OIC)
  - Report what you see and know is happening
    - DA 4106 (Near miss and actual event incident report)
    - Safety Reports
    - CA1/CA 16 (civilian employees)
- *Get involved with our patient safety program*
  - Our patients are counting on you to do everything you can to help them
- *Investigate (if in a position to do so)*
  - Root Cause Analysis
  - Line of duty investigations
  - Quality Improvement investigations

# *Risk Management*
# How do "I" put this into action?

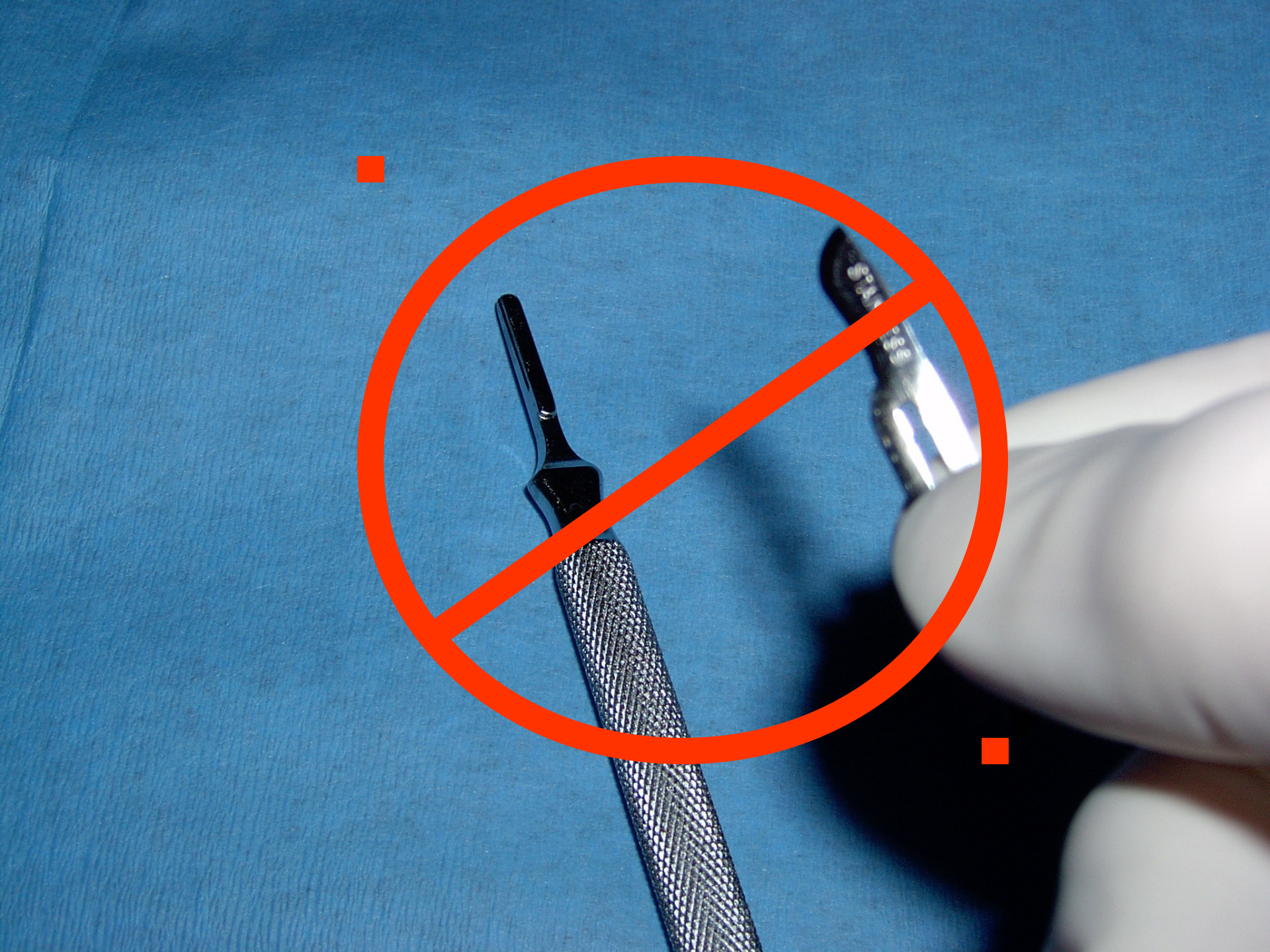
- *Understand your role in looking for and responding to risky situations*
- *Accept this very important role*
- *Look for ways to address what you find*
  - Next few slides show a response to something risky

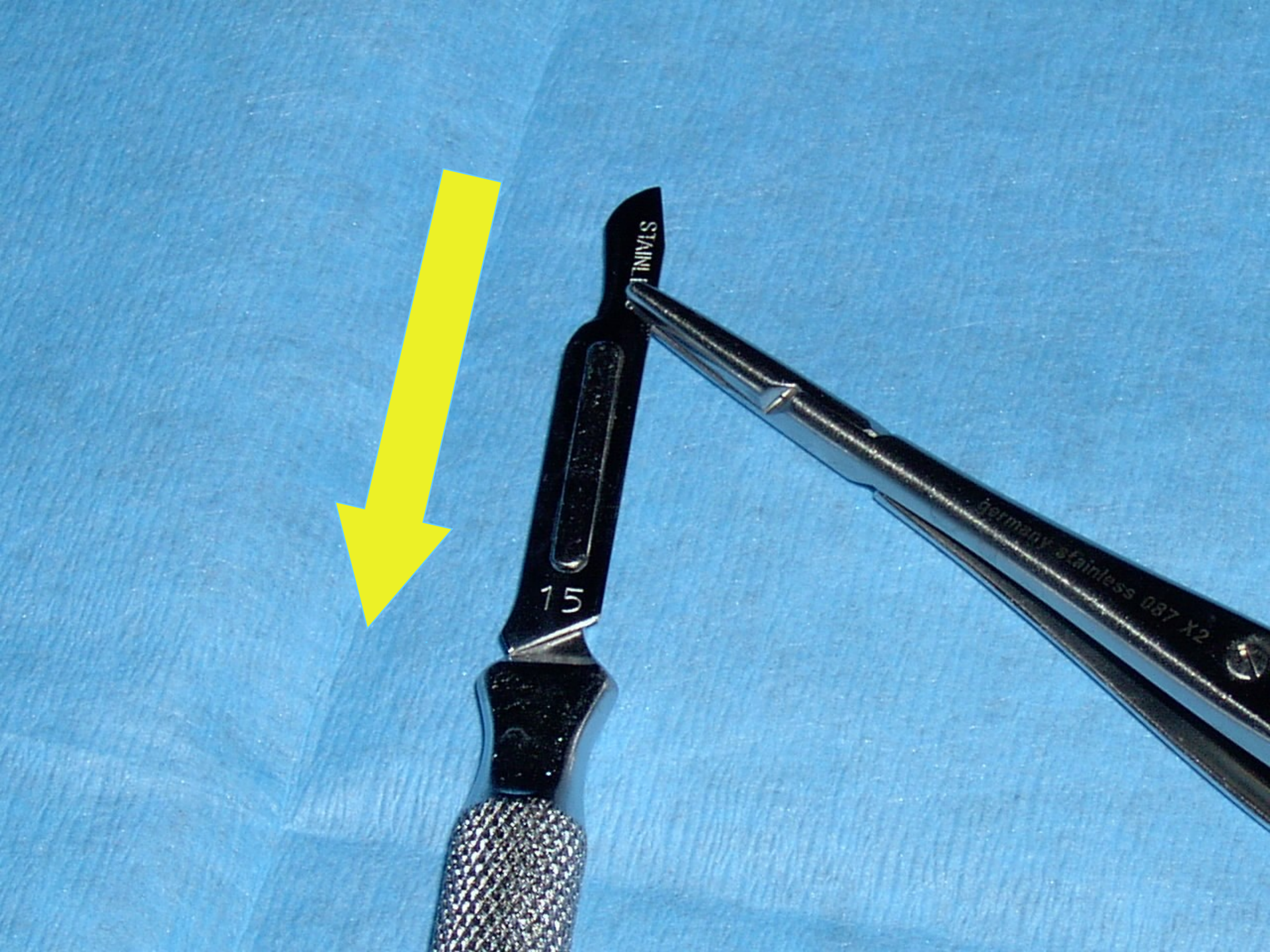
***What is wrong with this picture?***

***Touching a blade or sharp instrument is a very UNSAFE PRACTICE!!!***


What should we do when we see an UNSAFE PRACTICE?
Do something about it!
Speak Up
Interrupt behavior
Educate

# BLADE + FINGERS = INFECTION

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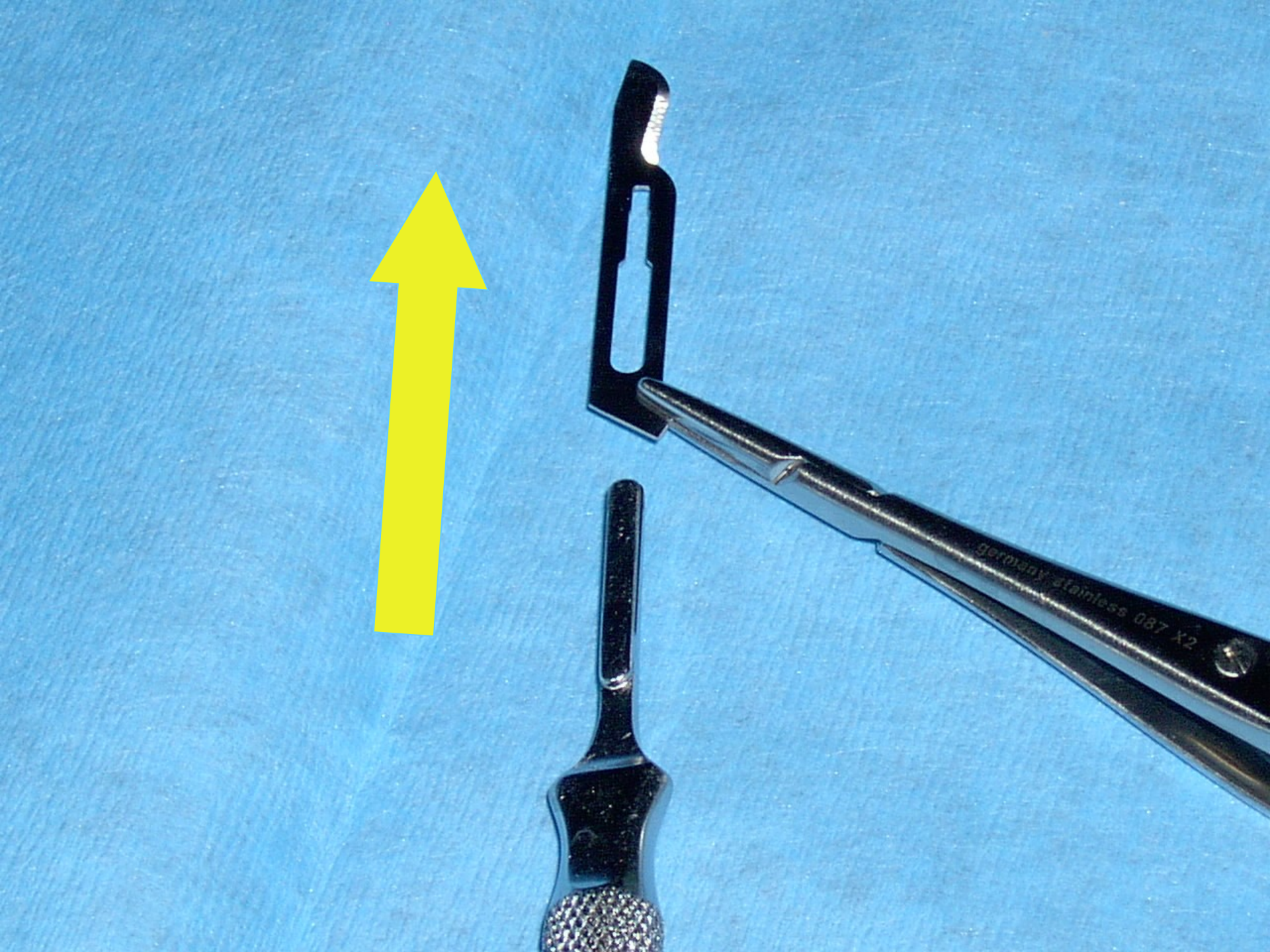
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# Which Finger Do YOU Want?

# *Risk Management*
# How do "I" put this into action?

- *Employees*
  - Ensure competency for procedure at hand for self and staff
  - Obtain appropriate training for the position you and your staff are in
  - Provide training for others if able to do so
  - Be aware of ergonomics for self and others
  - Notice and address potential injury producing situations
  - Use ***TEAM APPROACH*** – Stop at-risk events ON THE SPOT!

# *Risk Management*
# How do "I" put this into action?

- ***Facilities***
  - Ensure all equipment is working properly and speak up if it is not, i.e. Work order
  - Minimize access to unauthorized personnel, i.e. Close outside doors
  - Ensure building/operatory is in good condition
    - Minimize tripping/falling hazards
      - Cords are managed
      - Sidewalks are clear
      - No standing water on floors
    - Clear operatories of "clutter"
    - Standardize operatories

# *Risk Management*
# How do "I" put this into action?

- *Patients – Clinical Interaction*
  - Patient education
    - Ensure patient fully understands their dental condition and specific treatment options
    - Informed consent (risks/benefits)
  - Documentation – 603/603A entries
    - Comprehensive entries in dental records
    - Informed consent (risks/benefits) OF 522

# PATIENT SAFETY
## What is it?

***Facilities***

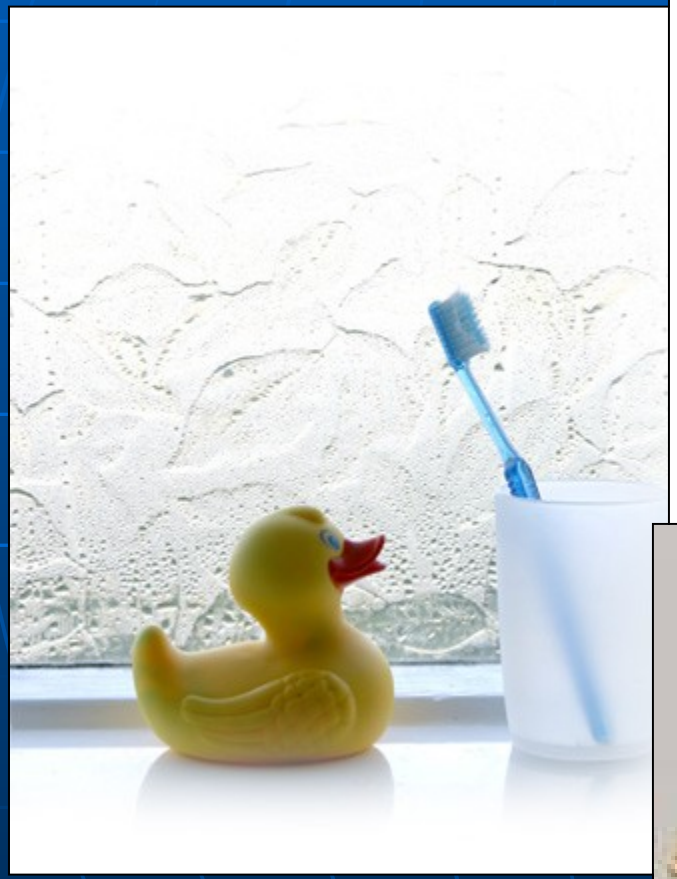
***Employees***

***Patient***

"SAFETY" PERSPECTIVE

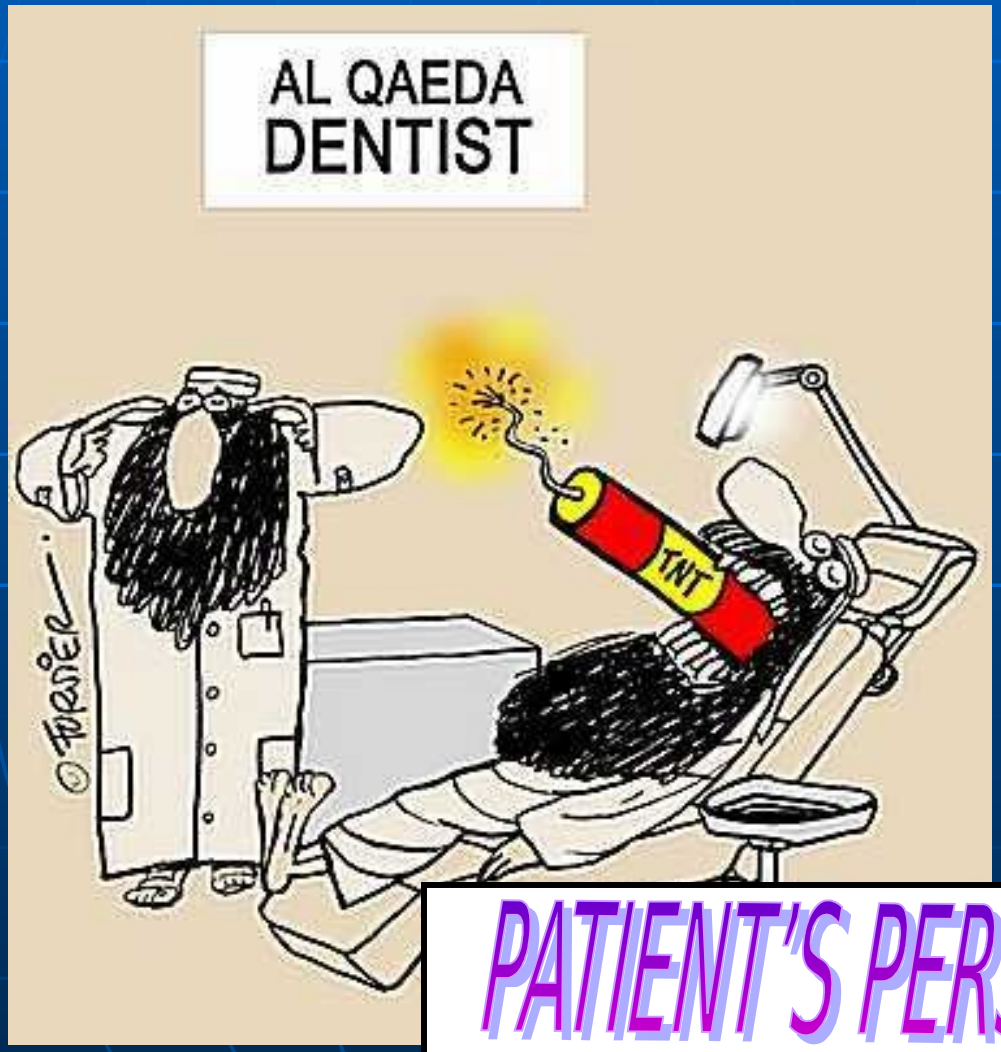
"PATIENT SAFETY" PERSPECTIVE

# IDEAL DENTAL EXPERIENCE




***EVERYONE IS HAPPY!!!***

# DENTAL EXPERIENCE
# IDEAL MEETS OUR REALITY




## PATIENT'S PERSPECTIVE

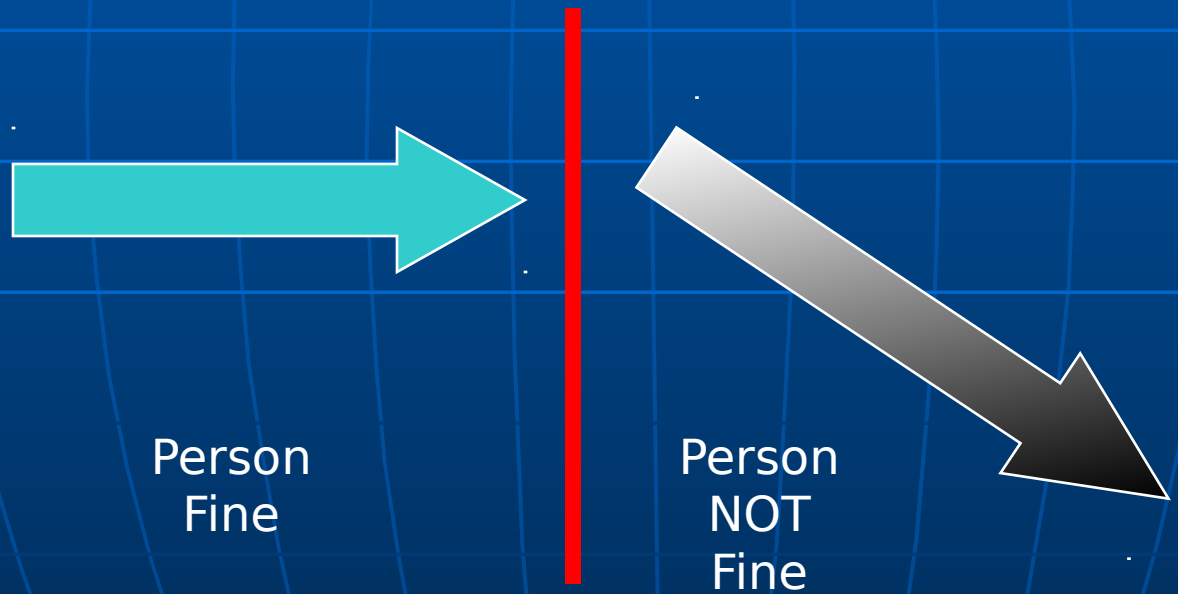
# *Patient Safety*
# What is it?

- ***Patient Care***
  - Patients have a right to freedom from accidental or preventable injury

- ***Providers and Staff: Have an opportunity to make a difference in patients enjoying that right***
  - Before - Proactively minimize likelihood of errors
  - Just Before - Intercept errors BEFORE they are about to occur
  - During – Intercept errors as they occur
  - After
    - Acknowledge errors occurred
    - Look for ways to eliminate error cause in future

# *MEDICAL EMERGENCY*
# *What Is It?*

- *Acute life-threatening situation*



# *MEDICAL EMERGENCY*
# *Why Worry Here?*

- *Acute life-threatening situation*

# *MEDICAL EMERGENCY*
# *Why Worry Here?*

- *Acute life-threatening situation*

# *Patient Safety*
# What are some "common" dental errors?

- *Wrong tooth removed or treated*
  - Handwriting illegible
  - Charting incorrect/reversed
  - Exam and/or documentation incomplete
  - Non-diagnostic radiographs
  - Reversed radiographs

# *Patient Safety*
# What are some "common" errors?

- *Injury from faulty instruments*
  - Poorly operating high-speed hand-piece
  - Dull bur
  - Clogged lines prevent water flow
- *Improper sterilization techniques*
- *Inappropriate medication prescribed*
- *Inappropriate anesthetic*
- *Inappropriate dosage administered*

# *Patient Safety*
# How do I combat common errors?

- *Medication errors*
  - Review health questionnaire EVERY TIME
  - Review medical history at least biannually
  - Prescriptions
    - Identify current meds and check for interactions
    - Use CHCS for all Rx
    - Call pharmacy if you need clarification
  - Seek assistance from another provider if unsure

# *Patient Safety*
# How do I combat common errors?

- *Remove or treat wrong tooth*
  - Perform Time Out properly
  - Confirm patient identity
  - Confirm correct record
  - Require and obtain diagnostic radiographs
  - Review and double check dental record
  - Call referring provider if unclear/unsure

# *Patient Safety*
# How do I combat common errors?

- *Faulty Equipment*
  - Keep maintenance logs
  - Daily/weekly equipment checks
  - Proper routine maintenance
  - Take defective equipment out of service

# *Patient Safety*
# How do I combat common errors?

- *Improper sterilization*
  - Ensure spore testing is being done properly
  - Ensure event-related sterilization
  - Ensure proper handling and packaging
  - Use PPEs
  - Use barriers

# *Patient Safety Summary*

## How can I ensure patient safety?

- *Do the right thing*
  - At the right time
  - All the time
- *Be alert*
- *Focus on your patient*
- *Be aware of your surroundings*
- *Realize how very important YOU are in meeting OUR MISSION*